**Submit this document to:**
**VCCB**
**Department of Administration**
**PO Box 110230**
**Juneau, Alaska 99811-0230**
**Facsimile – 907-465-3040**

**STATE OF ALASKA**

## VCCB TERMINATION REPORT: FORM V

This form is to be used if you are no longer conducting treatment.

Victim's Name _____

VCCB Claim Number _____

Client's Name (if different then the victim's) _____

Date treatment began _____

Clinician's Name and Provider Number _____ _____

Number of sessions to date _____

Clinician's Address _____

Clinician's Phone Number _____

_____

Please review the VCCB guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

**1)** Date of last session: _____

**2)** Diagnosis at the time the client stopped treatment:

**3)** Reason for termination (mark all that apply)

____ Current goals achieved

____ Client chose to terminate

____ Therapist choice to terminate

____ Parent/guardian choice to terminate

____ Client relocated

____ Client unavailable

____ Client referred to other services

___ Other

**4)** At this point in time, do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, please describe symptoms based on diagnostic criteria for a DSM diagnosis.